# STATE OF MISSOURI
# SOCIAL HISTORY INTERVIEW

Missouri First steps EARLY INTERVENTION

Child's Name: _____ Date of Birth: _____

**A. Date of Interview:** _____

Interviewer:_____ Information Provided By:_____

**B. Reason for Referral ***

Review the reason(s) for referral with the family members. See original Referral Form for this information. Include medical condition/need requiring assistance. Does the family agree with the referral? Do they see things differently? Briefly summarize this discussion below.

_____

_____

_____

_____

Existing Diagnosis, if known: _____

**C. Screening/Assessment/Testing History ***

Please list dates of previous screening, assessments or other tests (including birth or developmental screening, vision and hearing, nutrition, speech, gross and fine motor movement, adaptive skills, cognitive abilities, etc.).

| Date | Test Administered | By Whom | Results | Date | Test Administered | By Whom | Results |
|---|---|---|---|---|---|---|---|
| | Vision | | | | | | |
| | Hearing | | | | | | |
| | Developmental Screen | | | | | | |

*Indicates information to be entered and stored electronically at the System Point of Entry

**D. Health Care Received in the Past 12 Months (Copy additional pages of this section as needed)** List primary care physician for all well-child care including immunizations, medical care by specialty type, hospitalizations, surgeries within the last twelve (12) months. Include any services including therapies that the child now receives. Summarize contact information.

| ***PRIMARY CARE PHYSICIAN Name:** | # OF VISITS: | DATE LAST SEEN: | PCP# |
|---|---|---|---|
| *ADDRESS: | | *TELEPHONE: ( )<br>* FAX: ( ) | |
| REASON(S): | | | |

**CIRCLE: WELL CHILD CARE/CLINIC SERVICES VISION DENTAL SPECIALTY (TYPE:_____) HOSPITAL: _____**

| *NAME: | # OF VISITS | DATE LAST SEEN: |
|---|---|---|
| *ADDRESS: | | *TELEPHONE: ( )<br>*FAX: ( ) |
| REASON(S): | | |

**CIRCLE: WELL CHILD CARE/CLINIC SERVICES VISION DENTAL SPECIALTY (TYPE:_____) HOSPITAL: _____**

| *NAME: | # OF VISITS | DATE LAST SEEN: |
|---|---|---|
| *ADDRESS: | | *TELEPHONE: ( )<br>*FAX: ( ) |
| REASON(S): | | |

**CIRCLE: WELL CHILD CARE/CLINIC SERVICES VISION DENTAL SPECIALTY (TYPE:_____) HOSPITAL: _____**

| *NAME: | # OF VISITS | DATE LAST SEEN: |
|---|---|---|
| *ADDRESS: | | *TELEPHONE:( )<br>*FAX: ( ) |
| REASON(S): | | |

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**E. What is happening now for your child?**

**1. What type(s) of equipment is currently used by your child? ( Ö accordingly and complete)**

| | | | |
|---|---|---|---|
| | Wheelchair: Who provides/pays? | | Walker:Who provides/pays? |
| | Splints/AFOs: Who provides/pays? | | Eye Glasses:Who provides/pays? |
| | Adaptive Seating:Who provides/pays? | | Hearing Aids:Who provides/pays? |
| | Adaptive Bathing:Who provides/pays? | | Braces:Who provides/pays? |
| | Feeding Aids:Who provides/pays? | | Assistive Communication Device(s): Who provides/pays? |
| | Other: | | Other: |

**2. What medical, health equipment or supplies are routinely used by your child? ( Ö accordingly and complete)**

| | | | |
|---|---|---|---|
| | Apnea Monitor | | Oxygen |
| | Prescription Drugs | | Feeding Tube |
| | Ventilator (dependent) | | Other: |

**3. Current Medications (specify type, route and purpose) used by your child**

| Medication | Route (tube, mouth) | Purpose |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**E. What is happening now for your child? (continued)**

**4. Child's special diet:** Yes_____ No_____ Type_____

Who provides/pays? _____

**F. Developmental Milestones**

| FEEDING SKILLS | | | | | |
|---|---|---|---|---|---|
| | Formula/Breast fed only | | Needs to be fed | | Sucks/Chews on crackers |
| | Eats soft foods only | | Holds own bottle | | Needs assistance with eating |
| | Finger Feeds | | Eats solid foods | | Uses cup independently |
| | Feeds self w/spoon | | Feeds self w/fork | | Other: |

Comment:

Is this an area of concern? NO YES: _____

| FINE MOTOR SKILLS | | | | | |
|---|---|---|---|---|---|
| | Reaches for objects | | Plays with toys, one hand | | Plays with toys, both hands |
| | Claps hands, plays patty cake | | Puts toys into containers | | Picks up small objects |
| | Stacks block | | Scribbles with crayon | | Other: |

Comment:

Is this an area of concern? NO YES: _____

| GROSS MOTOR, MOBILITY | | | | | |
|---|---|---|---|---|---|
| | Head needs support | | Holds head steady | | Rolls Over |
| | Sits with Support | | Sits Independently | | Pulls to standing |
| | Crawls on hands and knees | | Cruises holding on to things | | walks with assistance |
| | Walks independently | | Can climb stairs | | Other: |

Comment:

Is this an area of concern? NO YES: _____

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Child's Name: _____ Date of Birth: _____ Date: _____

| COMMUNICATION SKILLS | | | | | |
|---|---|---|---|---|---|
| | Eyegaze (familiar face/voice) | | Smiles | | Grunts |
| | Points | | Babbles, no words yet | | Uses single words/phrases |
| | Talks in sentences | | Speaks clearly | | Other: |

Comment:

Is this an area of concern? NO YES: _____

| SELF HELP OR ADAPTIVE SKILLS | | | | | |
|---|---|---|---|---|---|
| | Needs to be dressed | | Wears diapers | | Removes socks, shoes |
| | Cooperates in dressing | | Toilet training in process | | Dresses Independently |
| | Fully toilet trained | | Other: | | Other: |

Comment:

Is this an area of concern? NO YES: _____

| SOCIAL SKILLS | | | | | |
|---|---|---|---|---|---|
| | Smiles | | Expresses comfort/discomfort | | Responds to primary caregiver |
| | Laughs | | Shows affection to familiar people | | Shows different emotions |
| | Anxious when separated from caregiver | | Interest in peers | | Other: |

Comment:

Is this an area of concern? NO YES: _____

| COGNITIVE SKILLS | | | | | |
|---|---|---|---|---|---|
| | Looks to floor when something falls | | Attains completely hidden object | | Imitates body action on a doll |
| | Uses a stick to try to attain an object | | Matches two sets of objects by item | | Assembles three –piece body puzzle |
| | Understands concept of one | | Matches four shapes | | Other: |

Comment:

Is this an area of concern? NO YES: _____

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**G. Pregnancy, Birth and General Health History**

Is there anything important about your pregnancy with your child, or his/her birth or early health history that will be helpful to us in determining your child's eligibility or in planning services together?

**1. Pregnancy ( Ö accordingly)**

a. Child was adopted Age at adoption: _____

b. Normal pregnancy reported

c. What month of the pregnancy did you start to see a medical provider?_____

Did you have regular medical care during this pregnancy? _____ YES _____ NO

d. During the pregnancy with this child, were any of the following present? ( √ accordingly)

| | | | | | |
|---|---|---|---|---|---|
| | Anemia | | Flu | | Prescription Drugs |
| | Bleeding | | Vomiting | | Non-Prescription Drugs |
| | Heart Disease | | Toxemia | | Alcohol/Drugs |
| | German measles | | Kidney disease | | Threatened miscarriage |
| | Virus:(type) | | Measles | | Early contractions |
| | Elevated blood pressure | | Injury | | Early bed rest |
| | Diabetes | | Pre-eclampsia | | Swollen ankles |
| | Other illness: (type: ) | | Other illness: (type: ) | | Smoking |

COMMENTS:

_____

_____

_____

**1. Pregnancy ( Ö accordingly) (continued)**

e. Type of delivery: (√ accordingly)

| | | | | | |
|---|---|---|---|---|---|
| | Vaginal delivery | | Breech delivery | | Multiple Birth |
| | Caesarean delivery | | Premature delivery | | Other: |

Comment:

f. Was any anesthesia used during childbirth? _____ No _____ Yes: Type: _____

g. Length of Labor: _____ hours

h. Were there any problems/complications during delivery? 1) for the mother:_____ No _____ Yes: What?_____

2) for the child: _____ No _____ Yes: What?_____

i. Were there any problems/complications after delivery? 1) for the mother:_____ No _____ Yes: What?_____

2) for the child: _____ No _____ Yes: What? _____

j. Weight gain during pregnancy: _____

**2. Newborn Status**

a. Check (√) any of the following which may apply.

| | | | | | |
|---|---|---|---|---|---|
| | Healthy, no problems | | Breathing problems | | Ventilator (how long: ) |
| | Jaundice | | Delayed crying | | Irregular heart beat |
| | Low birth weight | | Seizures | | Cord around neck |
| | Other: | | | | |

b. Newborn Information

| **Child's Birth Weight** | **Birth Length** | **APGAR Scores** | | |
|---|---|---|---|---|
| Grams/pounds | cm/inches | @ 1 minute: | @ 5 minutes: | @ 10 minutes: |

c. Where was your child born? _____
Hospital Name/City/State

d. Did your child go home with you? _____ Yes _____ No

e. Length of Hospital Stay: Child: _____ days Mother: _____ days

f. Was your child transferred to another hospital? _____ No _____ Yes: Which hospital? _____
Hospital Name/City/State

g. How has your child's general health been since birth? (√ accordingly)

| | | | | | |
|---|---|---|---|---|---|
| | Healthy, no problems | | Surgery(s) | | Vision problems: |
| | Sleeping problems | | Feeding problems | | Hearing problems: |
| | Repeated hospitalizations | | Vomiting problems | | Other: |

Comments:

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Note below any additional information including hospital discharge summary or reports provided during this interview:

**H. The family needs information or asked questions about the following:**